SECTION IV. 1. Case Management Services

A. Definition

"Case Management Services" assist individuals in gaining access to needed Choices for Care (CFC), VT Long-Term Care Medicaid services as well as other medical, social, and educational services, regardless of the funding source for the services to which access is gained. Case Management Services provide detailed needs assessment and assist the individual in creating a comprehensive CFC Service Plan. Case Management Services provide ongoing assessment and monitoring. Case Management Services assist the Department of Disabilities, Aging and Independent Living (DAIL) in monitoring the quality, effectiveness and efficiency of CFC services.

B. Case Management Standards

Case Management providers shall be authorized by the Department of Disabilities, Aging and Independent Living (DAIL) and comply with the following:

1. DAIL Case Management Standards & Certification Procedures

2. CFC Universal Provider Qualifications and Standards (*Section III.)*

3. CFC Services Principles (*Section IV*.)

C. Provider Types

The following provider types are approved to provide Case Management Services when authorized by DAIL and identified on the individuals Service Plan:

1. Area Agencies on Aging

2. Home Health Agencies *(as defined by State statute)*

D. Approved Activities

Case Management Services includes the following reimbursable activities:

1. Assessment: A comprehensive review of the individual circumstances, including, but not limited to, social, medical, functional, financial and environmental needs.

2. Care-Planning: A formal process of identifying the needs of the individual as identified in the assessment process. A plan is then developed to meet the identified needs and services to be delivered.

3. Service Coordination: The process by which services are obtained for the individual through coordination with multiple resources and providers.

4. Information and Referral: The process by which the individual is fully informed of available options and referrals are made as needed.

5. Monitoring: Ongoing review of individual's status, needs and service utilization.

6. Consumer & Surrogate Employer Certification: The process of assessing and reassessing an employer's certification for the home-based consumer or surrogate directed option.

7. Documentation: Documentation includes all required CFC forms, applications for other services or public benefits as needed and the documentation of ongoing case management activities.

8. Travel: Travel time includes getting to and from participant home-visits (or other face-to-face participant visit) and care-planning meetings related to individual service coordination.

E. Limitations

1. Case Management Services are limited to the "approved activities" for individuals authorized by DAIL for Choices for Care in the Home-Based or Enhanced Residential Care (ERC) setting.

2. Case Management Services are limited to a maximum of 48 hours per individual per calendar year. The State may approve higher volumes of case management services on a case-by-case basis, via the Service Plan approval process. The case manager must submit a brief written justification of the need for a higher volume of case management with the Service Plan document.

3. Case Management Services may not be delegated to another case manager except under short-term, temporary situations.

4. Case Management Services may be provided and billed for up to 180 days after admission and/or preceding discharge from a nursing facility or hospital, when such services are clearly documented as facilitating the individual's return to the community. Claims for such case management services must be submitted after the actual date of discharge from the hospital or nursing facility, as a single claim.